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DIVISION OF HEALTH CARE FINANCING AND POLICY	SECTION: 600
MEDICAID OPERATIONS MANUAL	SUBJECT: INTRODUCTION

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INTRODUCTION

Under Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), States are allowed the option to make Medicaid benefits available to eligible children with disabilities who would not ordinarily qualify for Supplemental Security Income (SSI) benefits because of the parents' income or resources.

Section 134 is also known as the "Katie Beckett" Option in reference to the child whose disability prompted this change. Under the Katie Beckett Eligibility Option Medicaid eligibility category, a State is allowed to waive the deeming of parental income and resources for a disabled child under 19 years of age who would be eligible for Medicaid if he or she were in a medical institution and who is receiving, while living at home, medical care that would normally be provided in a medical institution.

The child must require a level of care (LOC) that would make him or her eligible for placement in a hospital, nursing facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF/MR). A physician must sign a statement indicating that it is appropriate for the child to receive services in the home. These eligibility criteria are redetermined on an annual basis or in the case of a Pediatric Specialty Care level, every six months.

For children who become eligible for Medicaid under the Katie Beckett Eligibility Option, Medicaid covers medically necessary services as defined by the Medicaid State Plan. Waiver services, by their nature, are not available to children enrolled in the Katie Beckett Eligibility Option.

There is a monetary limit to the Medicaid medical coverage costs. The cost of the child's care in the home must be no greater than the amount Medicaid would pay if the child was institutionalized.

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STATUTORY AUTHORITY

Federal regulations governing the administration of the Katie Beckett Eligibility Option are referenced in the following locations:

1. Section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (Public Law 97-248). This Section of the Act focuses on Medicaid coverage of home care for certain disabled children
2. Section 1902 (e) (3) of the Social Security Act. Section 134 of TEFRA amends Section 1902 (e) (3) of the Social Security Act by adding the following option for each state: any individual who is 18 years of age or younger and qualified as a disabled individual under section 1614(a); determination by the State that the individual requires a LOC provided in a hospital, SNF, or ICF; is appropriate to provide such care for the individual outside such an institution; the estimated amount, which would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount which would otherwise be expended for medical assistance for the individual within an appropriate institution; and if the individual were in a medical institution, would be eligible to have a Supplemental Security Income (SSI) or State supplemental payment made with respect to the individual under Title XVI, shall be deemed, for purposes of this title only, to be an individual with respect to whom a Supplemental Security Income payment, or State supplemental payment respectively, is being paid under Title XVI.
3. Title 42 of the Code of Federal Regulations, Section 435.225 (42CFR435.225) relates to individuals under age 19 who would be eligible for Medicaid if they were in a medical institution. The Code states that the agency may provide Medicaid to children 18 years of age or younger who qualify under section 1614(a) of the Act, who would be eligible for Medicaid if they were in a medical institution, and who are receiving, while living at home, medical care that would be provided in a medical institution; if the agency elects the option provided by paragraph (a) of this Section, it must determine, in each case, that the following conditions are met:
 - a. The child requires the LOC provided in the hospital, SNF, or ICF;
 - b. It is appropriate to provide the LOC outside such an institution; and
 - c. The estimated Medicaid cost of care outside an institution is no higher than the estimated Medicaid cost of appropriate institutional care.

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- d. The agency must specify in its State Plan the method by which it determines the cost-effectiveness of caring for disabled children at home.

1. State Plan Supplement 3 to Attachment 2.2-A: Method for Determining Cost Effectiveness of Caring for Certain Disabled Children at Home (Katie Beckett Eligibility Option) states the following:

“At the end of each calendar quarter, a list of approved Katie Beckett Eligibility Option cases is generated by Division of Health Care Financing and Policy (DHCFP) District Office (DO) staff. The list shows the Medicaid expenditure amount incurred for that quarter for each eligible child under the Katie Beckett Eligibility Option. DHCFP DO staff compare the amounts incurred per child to the maximum amount that would have been allowed based upon the appropriate institutional level of care. If the incurred amount exceeds the maximum allowable amount, the eligibility worker at the appropriate Division of Welfare and Supportive Services (DWSS) DO is notified by DHCFP DO Katie Beckett Eligibility Option staff to contact the participant’s parent or legal guardian and advise him or her: 1) of the requirement to keep costs at or below the maximum allowable amount; and 2) that failure to keep costs at or below the maximum allowable amount for a second consecutive quarter will result in termination of Medicaid eligibility under the Katie Beckett Eligibility Option.

If the participant’s incurred costs exceed the maximum allowable amount for two consecutive quarters, he or she will be terminated from the Katie Beckett Eligibility Option, and consequently from Medicaid services, effective the first day of the month following the date of determination of non-compliance with program requirements.

An exception to this requirement occurs when a participant is re-evaluated by DHCFP and determined to require a higher level of care (thereby increasing the maximum allowable amount).”

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602 DEFINITIONS

602.1 CARE COORDINATION

Links persons who have complex personal circumstances or health needs that place them at risk of not receiving appropriate services to those services.

602.2 COST TRACKING

The method by which DHCFP monitors and tracks reimbursement for medical services to ensure that the established level of care cost limitations are not exceeded.

602.3 DIAGNOSIS

The determination of the nature or cause of physical or mental disease or abnormality through the combined use of health history, physical developmental examination, and laboratory tests.

602.4 DIARY or DIARY DATE

Specific to the Katie Beckett Eligibility Option, the diary date drives the physician consultant's disability reevaluation date. The disability reevaluation date can be established for one, two or three years from the initial disability determination date.

602.5 DISABILITY DETERMINATION

DHCFP's physician consultant and professional staff make up the disability determination team. The team reviews medical documentation and determines if the applicant qualifies based on Social Security Disability Standards. Those standards outlined by Social Security Disability are:

1. The child/participant must have a physical or mental condition(s) that seriously limits his or her life activities; and
2. The condition(s) must have lasted, or be expected to last, at least one year or the condition is expected to be terminal.

602.6 ELIGIBILITY

References a person's status to receive Medicaid program benefits. Eligibility is determined by Division of Welfare and Supportive Services (DWSS) based upon specific criteria for the Katie Beckett Eligibility Option.

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602.7 HEALTH EDUCATION

The guidance (including anticipatory) offered to assist in understanding what to expect in terms of a child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

602.8 INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF/MR)

An institution (or distinct part of an institution) which is primarily used for the diagnosis, treatment, or rehabilitation for persons with mental retardation or a related condition. In a protected residential setting, an ICF/MR facility provides ongoing evaluation, planning, 24-hour supervision, coordination, and integration for health and rehabilitative services to help individuals function if or when they are able to return home.

602.9 INTERMEDIATE CARE SERVICES FOR THE MENTALLY RETARDED

Health and rehabilitative services provided to a mentally retarded person or person with a related condition. The services are certified as needed and provided in a licensed inpatient facility.

602.10 LEVEL OF CARE (LOC) ASSESSMENT

A screening assessment to determine if an applicant's or participant's condition requires the level of services provided in a hospital, Nursing Facility (NF), or ICF/MR.

602.11 NOTICE OF DECISION (NOD)

The method by which the DWSS advises the participant of his or her Medicaid eligibility status.

602.12 PARENTAL FINANCIAL RESPONSIBILITY (PFR)

The cost-sharing portion that enables a child to receive Medicaid coverage under the Katie Beckett Eligibility Option. PFR is based on evaluation of parental income and resources by DWSS with the PFR amount determined based upon a sliding fee schedule.

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602.13 PERIODIC

Intervals established for screening by medical, dental, and other health care providers to detect disease or disability that meet reasonable standards of medical practice. The procedures performed and their frequency depend upon the child's age and health history.

601.14 SCREENING

A methodical examination performed to determine a child's health status and to make appropriate diagnosis and treatment referrals.

602.15 TREATMENT

One or more medically necessary services or care options provided to prevent, correct or improve disease or abnormalities detected by screening and diagnostic procedures.

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603 POLICY

603.1 GENERAL ELIGIBILITY CRITERIA

Eligibility for Nevada Medicaid under Katie Beckett Eligibility Option allows the State to waive the deeming of parental income and resources for children who meet all of the following conditions:

1. The child must be under 19 years of age and determined to be disabled based upon Social Security Disability Standards.
2. The child must require a LOC that would make him or her eligible for placement in a hospital, nursing facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF/MR).
3. A physician must sign a statement indicating that it is safe and appropriate for the child to receive care in the home.
4. Expenditures must not exceed the amount that DHCFP would pay for Medicaid services if the child was institutionalized.
5. As an individual, the child's income and or resources do not exceed the limits established by DWSS. Income and resource limits can be obtained from DWSS.

603.2 ELIGIBILITY DETERMINATION

Applicants or participants must meet and maintain all eligibility criteria to remain on Medicaid under the Katie Beckett Eligibility Option. Eligibility determination is made on an annual basis by the combined efforts of the Division of Welfare and Supportive Services (DWSS), the Division of Health Care Financing and Policy (DHCFP) and the Division of Mental Health and Developmental Services (MHDS) when indicated.

1. DWSS processes applications to determine Medicaid eligibility.
 - a. Parental income and resources are waived when determining the child's eligibility.
 - b. DWSS evaluates parental income and resources to establish the dollar amount of the Parental Financial Responsibility (PFR), if any.
 - c. Collection of the PFR is the responsibility of DWSS.

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2. DHCFP staff in the DOs facilitate the processing of Katie Beckett Eligibility Option applications for Medicaid eligibility. Upon receipt of applicant information from DWSS, DHCFP DO staff:
 - a. Complete a face-to-face interview and conduct a formal assessment of the child in the home setting to determine if a LOC exists.
 - b. Facilitate the collection of medical records to forward to DHCFP's Physician Consultant and review team at the DHCFP Central Office for disability determination and redeterminations.
 - c. If a child does not meet a Nursing Facility (NF) LOC, but medical records provide information indicating there is either a mental retardation or related condition diagnosis, the parent(s) or guardian(s) is referred to MHDS for further assessment.
3. MHDS staff are responsible for the evaluation and determination of an ICF/MR LOC for mental retardation or related conditions.
 - a. DHCFP requires that the individual determining an ICF/MR LOC must be at least a Developmental Specialist III (DSIII) or a Qualified Mental Retardation Professional (QMRP).
4. Third Party Liability (TPL)
 - a. Refer to Medicaid Services Manual Chapter 100.
 - b. Participants eligible for Medicaid are required to pursue and/or maintain other health coverage if it is available at no cost to the recipient, parent, and/or legal guardian.

603.3 CARE COORDINATION

Care Coordination is a component of the services provided by the District Office staff in the continuum of care which assists the participant to remain in his or her home. The role of the Katie Beckett Eligibility Option Health Care Coordinator is to:

1. Facilitate access to medical, social, educational, and other needed services regardless of the funding source.
2. Monitor quarterly calendar costs incurred to ensure that expenditures are not exceeded for the allowable cost limits and assist the family in prioritizing services.

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3. Prepare parent or guardian for transition to other services when Medicaid eligibility is no longer met under the Katie Beckett Eligibility Option (i.e. SSI eligibility, age 19) and or assist with any ongoing or unmet needs.
 - a. Coordinate with DWSS caseworker to change eligibility category;
 - b. Refer to Medicaid Waiver programs as appropriate; and
 - c. Refer to community resources.
4. Make at least quarterly contact with parent or guardian by phone, letter or in person to ensure that all necessary services are accessed and identify any significant change in the child's condition or unmet needs, making referrals as necessary.
5. Conduct in-home visits with the child and parent or guardian for determination of a LOC, making appropriate referrals as necessary. The number of visits per year is driven by the LOC, but home visits are conducted at least annually.

603.4

LEVEL OF CARE

A Nursing Facility and Intermediate Care Facility for Mentally Retarded LOC is assigned for a one-year period of time after the initial assessment and evaluation. There is a home visit conducted at least annually to reassess the LOC.

Nursing Facility Pediatric Specialty Care I and Pediatric Specialty Care II (Mechanical Ventilator Dependent) LOC's are assigned for a six month period, and a reassessment of the LOC occurs every six months.

Service levels determine the monthly cost allowance available for services and supplies for the child.

1. Nursing Facility Standard. A child's condition requires the level of service provided by either a Skilled Nursing Facility (SNF) or an Intermediate Care Facility (ICF). Age appropriate consideration must be incorporated into the assessment. Children are not normally considered to meet a LOC unless the diagnosis and symptoms require medical treatment, intervention or oversight seven days per week.
2. Nursing Facility Pediatric Specialty Care I and Pediatric Specialty Care II (Mechanical Ventilator Dependent). Limited to participants from birth to 19 years of age, who are medically fragile and require specialized, intensive, licensed skilled nursing care beyond the scope of services than what is generally provided to the majority of nursing facility participants.

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To qualify for this LOC, a participant must be receiving highly skilled services which require special training and oversight. Pediatric Specialty Care rates are approved for a maximum of six months at a time. Each Pediatric Specialty Care I or II child's LOC must be reevaluated every six months.

3. Intermediate Care Facility for the Mentally Retarded (ICF/MR). MHDS determines the ICF/MR LOC.

603.5 RATE METHODOLOGY AND COST TRACKING

1. DHCFP uses the average daily Nursing Facility rates established by the DHCFP Rates & Cost Containment Unit. Rates for Intermediate Care Facilities for the Mentally Retarded (ICF/MR) are also established by the DHCFP Rates and Cost Containment Unit.
2. The rates for the ICF/MR facilities are averaged. This amount is then used when determining the allowable ICF/MR rate for each participant who meets an ICF/MR LOC.
3. A quarterly cost monitoring report is used to ensure that the costs incurred by Medicaid for each child does not exceed the projected costs of institutional care. Katie Beckett Eligibility Option DO staff notifies DWSS eligibility staff and the parent or guardian if Medicaid spending is over the maximum allowable limit, which could result in ineligibility for Medicaid under the Katie Beckett Eligibility Option.

603.6 AUTHORIZATION PROCESS

Medicaid eligibility does not guarantee payment for services. Medical services must be authorized based on medical necessity, specific program policy and limitations. Out of state medical care will not be paid unless the service is prior-authorized or an emergency. Services are authorized by the QIO-like vendor.

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MEDICAID OPERATIONS MANUAL	SUBJECT: HEARINGS

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HEARINGS

Refer to MEDICAID OPERATIONS MANUAL Chapter 3100 for information regarding Hearing Procedures.

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MEDICAID OPERATIONS MANUAL	SUBJECT: REFERENCES AND CROSS REFERENCES

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REFERENCES AND CROSS REFERENCES

Please consult chapters of the MEDICAID OPERATIONS MANUAL which may correlate with this chapter.

Chapter 100	Eligibility, Coverage and Limitations
Chapter 200	Hospital Services
Chapter 300	Radiology Services
Chapter 400	MH & Sub Abuse
Chapter 600	Physician Services
Chapter 800	Laboratory Services
Chapter 900	Private Duty Nursing
Chapter 1000	Dental Services
Chapter 1100	Ocular Services
Chapter 1200	Prescription Services
Chapter 1300	DME, Disposable Supplies and Supplements
Chapter 1400	Home Health Agency Services
Chapter 1500	Healthy Kids Program (EPSDT)
Chapter 1700	Therapy
Chapter 1900	Transportation Services
Chapter 2800	School Based Child Health Services
Chapter 3100	Hearings
Chapter 3300	Surveillance and Utilization Review Section (SURS)
Chapter 3500	Personal Care Aide (PCA) Program
Chapter 3600	Managed Care Organization